DEPARTMENT OF HEALTH AND FAMILY SERVICES
Division of Public Health
DPH 42017 (Rev. 01/05)

STATE OF WISCONSIN
s. 252.04, Wis. Stats.
(608) 267-3733
FAX: (608) 266-0049

WISCONSIN INITIAL REFUGEE HEALTH ASSESSMENT

Instructions:

The refugee health assessment must be done with a trained medical interpreter or a medical provider fluent in the refugee's language. The purpose of this form is to assess the initial health status of refugees entering Wisconsin. Completion of this form is voluntary.

Perform the following lab tests <u>as appropriate</u> as part of the initial refugee health assessment:

- ☐ Varicella screening if no verification of natural immunity
- ☐ Hepatitis A screening for Hmong refugees <19 years old (anti-HAV total, IgM anti-HAV and ALT) unless they have received the hepatitis A vaccine > 4 weeks ago
- ☐ Hepatitis B screening (anti-HBs, HBsAg, anti-HBc and IgM anti-HBc)
- ☐ Intestinal parasite screening, provide containers and instruct client with interpreter on collecting and returning specimens to the appropriate provider (e.g. clinic, local health department)
- ☐ Syphilis, Gonorrhea, Chlamydia and HIV testing
- ☐ CBC with differential
- ☐ Hemoglobin/hematocrit
- ☐ Urinalysis/pregnancy test
- ☐ Malaria screening if history or symptoms are suspicious of malaria
- ☐ Lead (children up to age six)
- ☐ UA/UC (Urinalysis/Urine culture)
- ☐ Other labs as appropriate for follow-up

Prior to initiating the health screening, verify the patient's admission status.

Admission status refers to the classification that allows the patient to legally remain in the United States. To identify a patient's status:

- Request they present their Arrival/Departure Record (form I - 94) or a letter from Office of Refugee Resettlement or an immigration judge that documents the patient's status.
- Review the item and identify whether the patient's status is that of a Refugee, Asylee, Cuban/Haitian Entrant, Victim of Trafficking or an Amerasian.

Complete all information; Name, Date of Birth, Gender, Voluntary Agency (VOLAG)*, Alien Number, Country of Origin and Race, U.S. Arrival Date, Date of *first* clinic visit, Class B Status, and reimbursement information** in space provided at the top of page 3.

***VOLAG** refers to refugee resettlement voluntary agency.

***Class B status** refers to a condition (mental or physical) that was identified on the medical examination conducted abroad prior to immigration to the United States. This condition represents a departure from normal health or well-being that is significant enough to possibly interfere with the person's ability to care for himself or herself, or to attend school or work, or that may require extensive medical treatment or institutionalization in the future.

Assess immunizations: Review overseas medical exam (DS 2053) (formerly form DS 2053) if available, and document immunization dates.
According to the Advisory Committee on Immunization Practices (ACIP):

- Refugees <19 - update series, or begin primary series if no immunization dates are documented.
- Refugees 19 years of age and older - assess for vaccines that are medically appropriate.

For measles, mumps, rubella indicate if there is **laboratory** evidence of immunity; if so, immunizations are not needed against that particular disease.

For varicella, if there is laboratory evidence of immunity or **reliable** history of the disease (e.g. dermatological manifestations), immunization is not needed.

Document immunization information on the Refugee Health Assessment. Always update the personal immunization record card and instruct the patient and/or family, using an interpreter when needed. Call the Wisconsin Immunization Program at (608) 267-9959 for free immunization consultation if needed.

Tuberculosis Screening:
Apply Mantoux skin test to all patients 6 months of age and older (regardless of BCG history), unless a rare medical contraindication is present. (Pregnancy is not a medical contraindication for Mantoux testing.)

Apply Mantoux skin test to all patients 6 months or under if the child has HIV infection or if the child was exposed to an individual with active TB disease. (Make an immediate public health referral on a child with these circumstances.)

Tuberculosis Screening Continued:
Schedule a child under 6 months of age who s not HIV+ or a close contact for a Mantoux skin test after their 6-month birthday.

Read Mantoux test in 48-72 hours and record results in millimeters of induration on page three of this form. Also, record skin test and chest x-ray information on the Wisconsin TB Record form number DPH 4756 and provide to patient/family.

Document results of QuantiFERON-TB test if done.

Indicate if the refugee has any medical risk factors, that increase the risk for breaking down with active TB disease such as immunosupression, low body weight, diabetes, etc.

Chest x-ray MUST be done if:

a. Mantoux is positive for the person's risk factors
b. Patient has been identified on their overseas medical exam (DS 2053) as having a class A or B TB condition
c. Patient is symptomatic (cough, fever, hemoptysis, night sweats, weight loss, etc.)
d. Patient is a recent contact to active TB disease (Make an immediate public health referral.)

Indicate on the assessment form if medications for TB disease and/or TB infection were prescribed.

Oral Health:
Complete this section in accordance with DPH oral health training. Check screening "not done" if you have **not** been trained.

Hepatitis A
Administer Hepatitis A screening panel for **Hmong** refugees < 19 years old who have not been vaccinated > 4 weeks ago. Screening should include anti-HAV total, IgM anti-HAV and ALT. The ALT only needs to be run if the IgM anti-HAV is positive.

Hepatitis B
Administer Hepatitis B screening panel including Hepatitis B surface antigen (HBsAg), Hepatitis B surface antibody (anti-HBs), anti-HBc and IgM anti-HBc. Screen all household contacts of carriers and immunize susceptibles. Refer those who are HBsAg positive for additional medical evaluation.

Consider STD and HIV screening for all sexually active patients.
Screen for syphilis by administering VDRL or RPR. Confirm positive VDRL or RPR by FTA-ABS/TPPA or other confirmatory test. Repeat VDRL/FTA in 2 weeks if lesions typical of primary syphilis are noted and person is seronegative on initial screening.

Chlamydia and gonorrhea testing using appropriate tests (even if asymptomatic).

Screen for other STDs if symptomatic or if patient reports possible exposure.

HIV testing requires a separate written consent, according to Wis Statute 252.15(2).

Intestinal Parasites:
Evaluate for eosinophilia by obtaining a CBC with differential.
Conduct stool examinations for ova and parasites. Three stool specimens should be obtained at least 24 hours apart.

- If parasites are identified, one stool specimen should be submitted 2-3 weeks after completion of therapy to determine response to treatment.
- Eosinophilia requires further evaluation for pathogenic parasites, even with 3 negative screening stool examinations.

NOTE: The Wisconsin Division of Public Health **does not** recommend the use of rapid tests for identification of these parasites.

Hemoglobin and hematocrit: Document results if done.

Pregnancy: Test if indicated and provide appropriate care or referrals.

Malaria: If symptomatic, obtain three thick and three thin smears to screen for malarial parasites.

Lead: Include lead screening when ordering lab work for children up to age six and for others as indicated

Assess for other health problems:
Hematological disorders (eosinophilia, anemia, microcytosis), dental caries, nutritional deficiencies, thyroid disease, otorhinologic and ophthalmologic problems, history of trauma, dermatological abnormalities. Height, weight, vision and hearing evaluation and blood pressure. Assess mental health needs (e.g., headaches, nightmares, and depression). Screen for suicide potential if indicated and provide appropriate referrals.

Communicable Disease Reporting:
Wisconsin statute Chapter 252.05 and administrative Rule Chapter HFS 145 require reporting of communicable diseases. Refer to Acute and Communicable Disease Case Report - DPH 4151
Indicate all referrals made for patient and if an interpreter is needed. Fill in all lab results in appropriate places throughout the form. **Write name, address, phone/fax number and contact person of the agencies that provide the health screening on page 3. Include the Physician/PA/NP name and date completed. Fax all completed forms to 608/266-0049 or mail them: Refugee Health Coordinator, PO Box 2659, Madison WI 53701-2659 For questions or further information on refugee health screening call the Wisconsin Refugee Health Coordinator at: (608) 267-3733**

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WISCONSIN INITIAL REFUGEE HEALTH ASSESSMENT

Client information is confidential under Wisconsin Statute 146.82 (1)
Read instructions before completing this form.

Admission Status: ☐ Refugee ☐ Asylee ☐ Cuban/Haitian ☐ Victim of Trafficking ☐ Amerasian

Name (last, first, middle): _____

Gender: _____ **Date of Birth** (month, day, year): _____ **Resettlement Agency/VOLAG**: _____

Alien or Visa Registration No.: _____ **Country of Origin:** _____ **Race:** _____

U.S. Arrival Date (month, day, year): _____ **Date of First Clinic Visit for Screening** (month, day, year): _____

Class B Status: _____ **How will clinic be reimbursed for this screening?** ☐ Medical Assistance ☐ Health Screening Contract ☐ Other

Vaccine- Preventable Disease/Immunization	Check if there is evidence of immunity; no immunization needed	**Immunization Date(s)**					
		Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr	Mo/Day/Yr
Measles	☐						
Mumps	☐						
Rubella	☐						
Varicella (VZV)	☐						
Diphtheria, Tetanus, and Pertussis (DTaP, DTP, DT)							
Diphtheria -Tetanus (Td)							
Polio (IPV, OPV)							
Hepatitis B (Hep B)							
***Haemophilus influenzae* type b (Hib)**							
Hepatitus A (Hep A)	☐						
Influenza							
Pneumococcal							

BCG: ☐ Yes Date(s): ☐ No ☐ Unknown

Tuberculosis Screening:

Mantoux Skin Test Reaction (check one)
Regardless of history of BCG.
☐ Given results:
Date Placed: _____
Date Read: _____
_____ mm induration
☐ Given, not read
☐ Not done

QuantiFERON-TB result:
☐ Positive ☐ Negative

Chest x-ray: (taken in U.S.) (check one)
☐ Normal
☐ Non-TB Abnormality
☐ TB- non-cavitary
☐ TB- cavitary
☐ Stable, old TB
☐ Pending
☐ Not done, explain:
_____

TB Therapy: (if indicated) (check one)
☐ Treatment for suspected or confirmed active TB prescribed
☐ Treatment for latent TB infection (LTBI) prescribed**;**
Date started: _____
☐ No LTBI treatment; Reason:
☐ Documented treatment overseas for active TB disease
☐ Pregnancy
☐ Refused
☐ Other: _____

Risk factors for TB disease:
☐ Medical risk factor (diabetes, immunosupression, substance abuse, low body weight, etc.)
Explain: _____

Oral Health: (check all that apply)
☐ Screening not done ☐ Caries experience
☐ Untreated caries ☐ No natural teeth
☐ Early Childhood Caries ☐ Sealants present

Comments: _____
☐ Periodontal disease risk factors or signs of inflammation present

Treatment urgency:
☐ Early ☐ No obvious problem
☐ Urgent ☐ Prevention

Hepatitis A Sreening

Total anti-HAV (check only one) ☐ Negative ☐ Positive ☐ Results pending
IgM anti-HAV (check only one) ☐ Negative ☐ Positive ☐ Results pending

ALT _____ (value**)**

Hepatitis B Screening

Anti-HBs (check only one) ☐ Negative ☐ Positive; Note: if positive, patient is immune ☐ Results pending

HBsAg (check only one) ☐ Negative ☐ Positive ☐ Results pending

Note: If positive, patient is infected with HBV and infectious to contacts, and it is especially important to screen all household contacts.

If positive HBsAg, were all household contacts screened? ☐ Yes ☐ No
If Yes, were all susceptibles started on vaccine? ☐ Yes ☐ No If No, why not? _____

Anti-HBc (check only one) ☐ Negative ☐ Positive ☐ Results pending ☐ Not done

IgM anti-HBc (check only one) ☐ Negative ☐ Positive ☐ Results pending ☐ Not done

Note: If positive, patient has acute HBV infection.

Sexually Transmitted Diseases: (check one for each of the following)

Syphilis

Screening tests (VDRL/RPR) ☐ Negative ☐ Positive; treated? ☐ Yes Tx: ☐ Not done, why?_____

Confirmation test (FTA/TPPA) ☐ Negative ☐ Positive; treated? ☐ Yes Tx: ☐ Not done, why?_____

Gonorrhea ☐ Negative ☐ Positive; treated? ☐ Yes ☐ No ☐ Results pending ☐ Not done, why?_____

Chlamydia ☐ Negative ☐ Positive; treated? ☐ Yes ☐ No ☐ Results pending ☐ Not done, why?_____

HIV* ☐ Negative ☐ Positive; referred to specialist? ☐ Yes ☐ No ☐ Not done, why?_____

Other, specify: ☐ Negative ☐ Positive; treated? ☐ Yes ☐ No ☐ Results pending ☐ Not done, why?_____

*If HIV testing is done, a separate signed consent form for HIV testing must be completed.

Intestinal Parasite Screening:

Was screening for parasites done? ☐ Screened, results pending ☐ Screened, no parasites found ☐ Screened, parasite(s) found:

(Check all that apply)

☐ Ascaris	Treated?	☐ Yes	☐ No	☐ Hookworm	Treated?	☐ Yes	☐ No
☐ Clonorchis	Treated?	☐ Yes	☐ No	☐ Schistosoma	Treated?	☐ Yes	☐ No
☐ Cryptosporidium	Treated?	☐ Yes	☐ No	☐ Strongyloides	Treated?	☐ Yes	☐ No
☐ Cyclospora	Treated?	☐ Yes	☐ No	☐ Trichinella	Treated?	☐ Yes	☐ No
☐ Entomoeba histolytica	Treated?	☐ Yes	☐ No	☐ Trichuris	Treated?	☐ Yes	☐ No
☐ Giardia	Treated?	☐ Yes	☐ No	☐ Other Specify: _____	Treated?	☐ Yes	☐ No

☐ Not treated, why: _____

☐ Not screened for parasites; why? _____

Hemoglobin? ☐ Yes; results:_____ ☐ No

Hematocrit: ☐ Yes; results: _____ ☐ No

CBC with differential done? ☐ Yes ☐ No
Was Eosinophilia present? ☐ Yes ☐ No ☐ Results pending If yes, was further evaluation done? ☐ Yes ☐ No

Pregnancy (check only one)

☐ Yes; expected date/place of delivery_____ ☐ No

Malaria Screening: (check only one)

☐ Not screened for malaria (not symptomatic) ☐ Screened, results pending ☐ Screened, no malaria species in blood smears found

☐ Screened, malaria species found (please specify): ☐ Ovale ☐ Falciparum ☐ Vivax ☐ Malariae ☐ Not identified

If malaria species found: Treated? ☐ Yes ☐ No Referred for malaria treatment? ☐ Yes ☐ No

If referred for malaria treatment, specify physician/clinic: _____

Lead screening: (check only one) ☐ Yes Results: _____ ☐ No ☐ N/A

Significant information from patient history: _____

_____

Significant information from physical exam: _____

_____

Communicable Disease Reporting:

Wisconsin statute Chapter 252.05 and administrative Rule Chapter HFS 145 require reporting of communicable diseases. Refer to Acute and Communicable Disease Reporting - DPH 4151

Referrals: (check all that apply)

☐ Dental ☐ Vision ☐ Dermatology

☐ Communicable Disease, ID referral for: _____

☐ Communicable Disease, LHD referral for: _____

☐ Hearing ☐ Family Planning ☐ Public Health/WIC

☐ Medical/Other: _____

Mental Health (check as appropriate):

☐ Post traumatic stress disorder (PTSD) ☐ Depression ☐ Anxiety ☐ Adjustment issues

☐ Domestic issues ☐ Substance Abuse ☐ Learning problems ☐ Other

Interpreter needed: ☐ Yes ☐ No If yes, which language(s) _____

Screening provider: If more than one agency is involved in health assessment include information on both agencies.

Agency One: _____

Address: _____

Telephone: (____) _____

Fax: (____) _____

Agency Two: _____

Address: _____

Telephone: (____) _____

Fax: (____) _____

Submitter: _____ **Contact Number:** _____

Fax completed form to the Wisconsin Department of Health and Family Services, Division of Public Health, Bureau of Communicable Diseases, Refugee Health Coordinator at (**608) 266-0049** or mail to:

Division of Public Health
Attn Refugee Health Coordinator
PO Box 2659
Madison WI 53701-2659

Statement of Rights

Information on this form is collected for the Wisconsin Division of Public Health (DPH), by authority of Section 412(7) of the Immigration and Nationality Act as amended by the Refugee Act of 1980. This information is used to obtain a health evaluation and/or treatment for the patient. Wisconsin State Statute authorizes collection of this information under s. 250.04. In order to provide services, it may be necessary to release information from the patient's record to individuals or agencies that are involved in the care of the individual. Such individuals and agencies usually include family physicians and/or dentists, medical and dental specialists, public health agencies, hospitals, schools and day care centers. All public health agencies, health institutions, or providers to whom the refugee has appeared for treatment or services shall be entitled to the information included on this form.